MARKET CONDUCT EXAMINATION

AETNA HEALTH INC.
AETNA HEALTH OF WASHINGTON INC.

600 UNIVERSITY STREET, SUITE 1400
SEATTLE, WASHINGTON 98101

January 1, 2000 – December 31, 2001

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The Honorable Mike Kreidler
Washington State Insurance Commissioner
P.O. Box 40255
Olympia, Washington 98504

Dear Commissioner Kreidler:

Pursuant to your instructions and in compliance with the statutory requirements of RCW 48.03.010 and procedures promulgated by the National Association of Insurance Commissioners and the Office of the Insurance Commissioner (OIC), an examination of the market conduct affairs has been performed of:

Aetna Health of Washington Inc., NAIC #47060
Aetna Health Inc., NAIC #95484
600 University Street, Suite 1400
Seattle, Washington 98101

In this report, Aetna Health of Washington Inc. is referred to as "HCSC." Aetna Health Inc. is referred to as "HMO." Collectively these entities are referred to as "the Companies."

This report of examination is respectfully submitted.

CHIEF EXAMINER'S REPORT CERTIFICATION and ACKNOWLEDGEMENTS

This examination was conducted in accordance with Office of Insurance Commissioner and National Association of Insurance Commissioners market conduct examination procedures. Nancy L. Barnes, AIE, ACS, George J. Lazur, AIE, CPCU, and Charlotte F. Wright of the Washington State Office of Insurance Commissioner performed this examination and participated in the preparation of this report.

The examiners wish to express appreciation for the courtesy and cooperation extended by the personnel of Aetna Health of Washington Inc. and Aetna Health Inc. during the course of this market conduct examination.

I certify that the following is the report of the examination, that I have reviewed this report in conjunction with pertinent examination work papers, that this report meets the provisions for such reports prescribed by the Office of Insurance Commissioner, and that this report is true and correct to the best of my knowledge and belief.

Leslie A. Krier, AIE, FLMI
Chief Market Conduct Examiner
Office of the Insurance Commissioner
State of Washington

FORWORD

This examination was completed by applying tests to each examination standard. East test applied during the examination is stated in this report and the results are reported. Exceptions are noted as part of the comments for the applied test. Throughout the report, where cited, RCW refers to the Revised Code of Washington, and WAC refers to Washington Administrative Code.

Scope

Time Frame

The examination covered the Companies' operations from January 1, 2000 through December 31, 2001. This was the first market conduct examination of Aetna Health of Washington Inc. and Aetna Health Inc. This examination was performed both in the Seattle OIC office and on-site at the Companies' offices in Seattle, Washington and Fresno, California.

Matters Examined

The examination included a review of the following areas:

Company Operations & Management	Advertising
Agent Activity	Claims
Complaints	Rate and Contract Administration
Member Contracts and Handbooks	Underwriting
Provider and Administrative Contracts	Claims

Sampling Standards

Methodology

In general, the sample for each test utilized in this examination falls within the following guidelines:

92 %	Confidence Level
+/- 5 %	Mathematical Tolerance.

Regulatory Standards

Samples are tested for compliance with standards established by the OIC. The tests applied to sampled data will result in an error ratio, which determines whether or not a standard is met. If the error ratio found in the sample is, generally, less than 5%, the standard will be considered as "met." The standard in the area of agent licensing and appointment will not be met if any

violation is identified. The standard in the area of filed rates and forms will not be met if any violation is identified. This will also apply when all records are examined, in lieu of a sample.

For those standards, which look for the existence of written procedures, or a process to be in place, the standard will be met based on the examiner's analysis of those procedures or processes. The analysis will include a determination of whether or not the company follows established procedures.

Standards will be reported as Passed (without Comment), Passed with Comment or Failed. The definition of each category follows:

Passed	There were not findings for the standard.
Passed with Comment	The records reviewed fell within the tolerance level for that standard.
Failed	The records reviewed fell outside of the tolerance level established for the standard.

COMPANY OPERATIONS AND MANAGEMENT

Company History

Aetna Health of Washington Inc. (HCSC) and Aetna Health Inc. (HMO) are indirect, wholly owned subsidiaries of Aetna Inc (Aetna).

HCSC was originally registered as Ethix Care, Inc. on November 17, 1994. On January 1, 1996, Ethix Care changed its name to NYLCare Plus, Inc. The name was changed again on February 14, 1996 to NYLCare Health Plans Northwest, Inc. In 1996, Aetna merged with U.S. Healthcare, and on August 14, 1998, Aetna acquired NYLCare Health Plans. Prudential Healthcare was acquired by Aetna August 6, 1999.

HMO was originally registered as Virginia Mason Health Plan, Inc. on December 26, 1985. On October 7, 1997, Aetna acquired Virginia Mason Health Plan, Inc. Documentation was filed with the Secretary of State on November 5, 1997 to rename this entity Aetna U.S. Healthcare Inc.

On April 3, 2002, HCSC and HMO filed documentation to change their names from Aetna U.S. Healthcare of Washington Inc. and Aetna U.S. Healthcare Inc. to Aetna Health of Washington Inc. and Aetna Health Inc., respectively. The name changes were effective May 1, 2002.

Company Management & Operations

A Board of Directors governs the Companies. The Board meets on a quarterly basis to discuss issues and to conduct oversight of operations of the Companies. Minutes from all meetings are maintained in the Woodland Hills, California offices. The current Board of Directors for both HCSC and HMO is:

Milton Dorian Schwarz, M.D., Regional Medical Director
Norman Seabrooks, Director of Business Development
Ellen Suzanne Daly, President of Aetna Health Inc. and Aetna Health of WA Inc.

The members of the Board of Directors are elected by a majority of the votes cast at the annual meeting of shareholders of HCSC and HMO to one-year terms. Each director holds office until the next succeeding annual meeting or until his successor has been elected and qualified.

The examiners reviewed the Companies' Certificates of Authority, Articles of Incorporation and Bylaws. The examiners found the Articles of Incorporation and the Bylaws to be in order.

Operations for the Western Region, which includes Washington state operations, are conducted in the following locations: Blue Bell, Pennsylvania; Seattle, Washington; San Ramon,

California; Rancho Cucamonga, California; Fresno, California; Woodland Hills, California; Tyler, Texas; Houston, Texas.

Territory of Operations

During the examination period, HCSC and HMO operated in 21 counties in Washington State. Primary care physicians are located in all counties in which the Companies operate. These counties are: Clallam, Grays Harbor, King, Kitsap, Lewis, Mason, Pierce, Skagit, Snohomish, Thurston, and Walla Walla. Specialists are also available to plan members in these counties along with specialists in ten (10) additional counties: Benton, Columbia, Cowlitz, Island, Jefferson, Kittitas, San Juan, Spokane, Whatcom, and Yakima.

The examiners did not find any evidence that the Companies are operating outside of their stated territory of operation.

Findings

The following Company Operations & Management Standards passed without comment:

#	Company Operations & Management Standard	Reference
1	The Company is required to be registered with the Office of Insurance Commissioner prior to acting as a health care service contractor or health maintenance organization in the State of Washington.	HCSC Reference RCW 48.44.015(1) HMO Reference RCW 48.46.027(1)

The following Company Operations & Management Standard failed:

#	Company Operations & Management Standard	Reference
2	The Company is required to report to the OIC any changes to the registration documents, including Articles of Incorporation, Bylaws, and Amendments at the same as submitting such documents to the Secretary of State.	HCSC Reference RCW 48.44.013 HMO Reference RCW 48.46.012
3	The Company is governed by a board nominated and elected by the voting members or enrolled participants and providers, and afforded a meaningful role in policy making of the Company. At least one-third of the board shall consist of consumers who are representative of the enrolled population.	HCSC Reference None HMO Reference RCW 48.46.030(2), RCW 48.46.070

Company Operations & Management Standard #2:

A Certificate of Administrative Dissolution was issued by the Secretary of State on May 26, 2000 to Aetna Health Inc (HMO). The dissolution was effective January 24, 2000 due to failure to file an annual list of officers and submit license renewal within the time frame set forth by law. An Application for Reinstatement was submitted on May 26, 2000 and approved by the Secretary of State. A copy of the Application for Reinstatement was not submitted to the OIC as required by RCW 48.46.012.

Company Operations & Management Standard #3:

The HMO board is currently comprised of three (3) members. All of the members are employed by the Companies. The Companies state that Mr. Seabrooks is representative of the consumer population as he is an enrolled participant of the plan. However, his employment with the Companies as Director of Business Development represents a conflict of interest. The enrolled participants cannot be assured a meaningful role in policy making if all board members are employees of the Companies.

The following General Examination Standards passed without comment:

#	General Examination Standard	Reference
1	The Company does business in good faith, and practices honesty and equity in all transactions.	HCSC/HMO Reference RCW 48.01.030
3	The Company may not discourage members from contacting the OIC and may not discriminate against those members that do contact the OIC.	HCSC/HMO Reference WAC 284-30-572(2)

The following General Examination Standards failed:

#	General Examination Standard	Reference
2	The Company must facilitate the examination process by providing its accounts, records, documents and files to the examiners upon request.	HCSC Reference RCW 48.03.030(1), RCW 48.44.145(2) HMO Reference RCW 48.03.030(1), RCW 48.46.120(2)

General Examination Standard #2:

The Companies were not able to readily produce documents requested by the examiners. Of the 21 additional information requests, the Companies required extensions on 11 in order to gather the requested items. When pressed to give the examiners a reason for the delay in getting them materials, the Companies stated that it was difficult to coordinate between their

administrative areas. The examiners found that many operational functions were handled in multiple locations. One of the best examples of this is that advertising materials are created in Blue Bell, PA. They are printed in Texas. They are distributed in the California and Washington offices. Because this changes on a regular basis, the Companies did not know where to locate the materials the examiners requested.

This caused a delay in the examination process as the Companies were not able to readily and easily produce documents for review. The Companies also admitted to "losing" documents between the offices. Thus, certain files or documents were not available to the examiners.

The Companies were not able to produce the following files for the examiners:

- The Companies stated that 12 of the complaint files requested by examiners could not be located in storage, or that system data had been purged.
- Three (3) of the new and renewal business files requested were either missing or did not contain complete information.
- The Companies could not produce three (3) of the provider contract files that were selected for review and could not provide the examiners with an explanation.
- One (1) file was missing from the claim sample. The explanation given to the examiners was that after 18 months claim records are archived and the Companies were unable to locate the archived records.

ADVERTISING

The Companies' advertising materials are prepared in the Marketing Communications Department in Blue Bell, Pennsylvania. This department also creates and maintains the Companies' website. The advertising material used in Washington State is maintained at and distributed by the Regional Marketing Communications department in Rancho Cucamonga, California.

The Companies provided a list of 79 items in the advertising file. A random sample of 50 items was selected from this list for review. The sample was selected using ACL software and was based on NAIC Market Conduct Examiners Handbook guidelines.

In the sample of 50 advertising pieces, three (3) items were not used in the State of Washington. Of the remaining 47 items, 42 were used to advertise both HCSC and HMO. Three (3) were used exclusively for HCSC, and two (2) were used exclusively for HMO. All of these items were in compliance with the advertising standards.

In addition to the sample materials, the examiners reviewed the Companies' internet website. The website contains information for both HCSC and HMO. The information is of an institutional advertising nature. The website allows access to plan information in each state. Brief descriptions of the plans and the availability of the plans in geographic locations are

included. Members can locate physicians, check claim status, request identification cards, obtain benefit summaries, contact customer service personnel, and access general health and wellness information. Agents can obtain information concerning licensing and appointment, compensation, and contact sales offices.

The Companies have established a quality management program in order to monitor standards of health care and measure enrollee satisfaction. Plan-specific HEDIS (Health Employer Data Information Set) and CAHPS (Consumer Assessment of Health Plans Survey) results are published on a "report card." This information is communicated to members via member newsletters. Newsletters are mailed quarterly. Identical information may also be obtained from the Companies' website.

Findings

The following Advertising Standards passed without comment:

#	Advertising Standard	Reference
1	The Company cannot advertise a plan to prevent illness or promote health unless a) the clinical preventive benefits are the same as the basic health plan; b) it monitors and reports annually to enrollees on standards of health care and satisfaction of enrollees; c) makes available its plan to identify and manage the most prevalent diseases within its enrolled population on request.	HCSC/HMO Reference RCW 48.43.510(5), WAC 284-43-820(5)
2	No advertising may contain any false, deceptive or misleading information	HCSC Reference RCW 48.44.110 HMO Reference RCW 48.46.400
3	The Company cannot make misleading comparisons with other companies to induce the consumer to change from another HCSC or HMO.	HCSC Reference RCW 48.44.140 HMO Reference RCW 48.46.410
4	The Company complies with the Washington Disability Insurance Advertising Regulations.	HCSC/HMO Reference WAC 284-50-010 through WAC 284-50-230
6	The Company must comply with all health plan disclosures as required by regulation.	HCSC/HMO Reference WAC 284-43-820
7	The Company cannot misrepresent the terms, benefits, or advantages of the contract.	HCSC Reference RCW 48.44.120 HMO Reference

#	Advertising Standard	Reference
		WAC 284-50-050, RCW 48.46.060(2) and (3)
8	The Company cannot guarantee future dividends or future refunds except in group contracts with an experience refund provision.	HCSC Reference
		RCW 48.44.130
		HMO Reference
		None
9	No HMO may use the words "insurance:, "casualty", "surety", or "mutual" to describe itself in its advertising materials.	HCSC Reference
		None
		HMO Reference
		RCW 48.46.110(1)
10	No advertisement can contain any type of endorsement of any state or government agency.	HCSC Reference
		See Standard #4
		HMO Reference
		RCW 48.46.310 (WAC 284-50-140)

The following Advertising Standard passed with comment:

#	Advertising Standard	Reference
5	The Company maintains a complete advertising file.	HCSC/HMO Reference
		WAC 284-50-200

Advertising Standard #5:

After the initial sample was provided, the Companies notified the examiners that the file was not complete. The examiners were subsequently provided with a copy of an advertisement that appeared in the New York Times on February 4, 2000. This institutional advertisement was for HMO.

The examiners also found that the Companies' website is not listed as a part of its advertising file. Draft pages of the information maintained on the website should be maintained in the file.

Since these advertisements were not included in the original listing of items in the advertising file, the Companies have not maintained a complete advertising file as required by WAC 284-50-200.

See Appendix 1.

COMPLAINTS

Procedures

The Companies provided the examiners with a copy of its Appeals and Grievances Procedures in use during the examination period. The procedures include three (3) levels of process and include definitions of all terms. The process is accurately described in the procedures.

The Customer Service Unit handles all routine inquires and verbal (telephone) complaints. This is the first level of the process. There are four (4) steps to this level. A description of this process can be found in the examiners work papers. The Regional Grievance and Appeals Unit (GAU) handles all grievances and appeals

Grievances and appeals of an urgent/emergent nature may be expedited. The process of an expedited appeal is facilitated either verbally or in writing via telephone, mail, or facsimile. Expedited grievances and appeals are coordinated by the GAU and the Companies' medical director.

At all levels of the process, data is documented and maintained on the Companies' computer system.

Complaint File Review

The Companies provided the examiners with a copy of their verbal complaint database. The Companies also provided the examiners with copies of their grievances database and appeals database. During the examination period, the Companies logged:

- 464 verbal complaints
- 404 grievances
- 924 appeals

The examiners selected a random sample of 50 files from each category for review. One (1) file in the appeals sample concerned the Basic Health Plan and was removed from the sample because it fell outside the scope of the examination. This left 149 files reviewed by the examiners.

The following charts show the reasons and dispositions of the 149 complaints, grievance and appeal files:

Verbal Complaints

Type	Number	Overturned	Upheld	No Decision	Withdrawn	Insufficient Data
Balance Billing	3	3	0	0	0	0
Benefits	5	0	3	2	0	0
Claim Handling	3	3	0	0	0	0
Eligibility	3	1	0	2	0	0
File Not Found	0	0	0	0	0	0
PCP/Network Adequacy	7	0	1	6	0	0
Policyholder Service	10	1	1	8	0	0
Preauthorization	2	0	0	2	0	0
Provider Reimbursement	0	0	0	0	0	0
Referrals	3	2	0	1	0	0
Rude Provider	14	0	0	14	0	0
Total	**50**	**10**	**5**	**35**	**0**	**0**

Grievances

Type	Number	Overturned	Upheld	No Decision	Withdrawn	Insufficient Data
Balance Billing	3	2	0	1	0	0
Benefits	2	1	0	1	0	0
Claim Handling	17	12	2	3	0	0
Eligibility	4	3	1	0	0	0
File Not Found	1	0	0	0	0	1
PCP/Network Adequacy	6	5	0	1	0	0
Policyholder Service	3	3	0	0	0	0
Preauthorization	3	2	0	1	0	0
Provider Reimbursement	1	0	0	1	0	0
Referrals	10	6	0	4	0	0
Rude Provider	0	0	0	0	0	0
Total	**50**	**34**	**3**	**12**	**0**	**1**

Appeals

Type	Number	Overturned	Upheld	No Decision	Withdrawn	Insufficient Data
Balance Billing	0	0	0	0	0	0
Benefits	8	5	2	0	0	1
Claim Handling	9	7	2	0	0	0
Eligibility	4	1	3	0	0	0
File Not Found	0	0	0	0	0	0
PCP/Network Adequacy	2	1	1	0	0	0
Policyholder Service	14	13	1	0	0	0
Preauthorization	2	1	0	0	1	0
Provider Reimbursement	0	0	0	0	0	0
Referrals	10	5	5	0	0	0
Rude Provider	0	0	0	0	0	0
Total	**49**	**33**	**14**	**0**	**1**	**1**

There were 77 files (51.7%) that had the initial determination overturned. The examiners discovered several factors contributing to the volume:

- The Companies' Claim Processing Guidelines (2001) instruct processors to adjudicate claims from non-participating providers at rates less than 100% of the Companies' usual, customary and reasonable (UCR) amounts. These issues are only overturned if the provider or member contacts the Companies. If the provider contacts the Companies, a claim would be reprocessed at 100% of UCR. Upon additional contact by the provider or member, claims are reprocessed and paid in full. This practice is discriminatory. Only when the Companies are contacted are additional claims payments made.

- Many of the complaints, appeals, and grievances reviewed concerned the choice of selecting or changing primary care physicians (PCP). Members may select or change their PCP in one of three ways: enrollment card, contacting customer service via telephone, or using the Companies' website. If a PCP is not selected at enrollment, the Companies do not followup with the member or the group to obtain this information. The examiners found that requested changes, both by telephone and through the Companies' website, are not confirmed. The Companies' failure to followup and promptly make requested changes results in unnecessary claim denial and a large number of complaints.

As previously discussed in the Company Operations & Management section of this report, HCSC and HMO were unable to provide complete responses to questions from the examiners on 12 files reviewed. Personnel within the Companies responded stating they were unable to locate files from storage or that system data had been purged and attempts to restore information were not successful.

OIC Complaints

During the examination period, the OIC received 123 complaints about HCSC and HMO. The examiners selected a random sample of 50 files to review. Four (4) complaints were logged by the Companies but were never received by the OIC. Three (3) complaints concerned Medicare, six (6) complaints were in regard to federal plans, and one (1) complaint was for a self-funded plan. These files were outside the scope of the examination and were removed from the sample leaving a total of 36 files reviewed by the examiners.

The following illustrates the reasons and dispositions of the complaints:

Type	Number	Overturned	Upheld	No Decision
Balance Billing	2	2	0	0
Benefits	2	1	1	0
Claim Handling	15	13	1	1
Eligibility	6	3	1	2
File Not Found	0	0	0	0
PCP/Network Adequacy	1	0	0	1
Policyholder Services	4	0	1	3
Preauthorization	1	0	1	0
Provider Reimbursement	3	0	1	2
Referrals	2	2	0	0
Rude Provider	0	0	0	0
Total	**36**	**21**	**6**	**9**

Findings

The following Complaint Standards passed without comment:

#	Complaint Standard	Reference
1	**The Company has filed a copy of its procedures for review and adjudication of complaints with the OIC.**	**HCSC Reference** **RCW 48.43.055**

#	Complaint Standard	Reference
		HMO Reference
		RCW 48.43.055, RCW 48.46.100
2	The Company has a means to disclose to an enrollee or prospective enrollee a copy of the grievance procedures for claims and for service denials as well as dissatisfaction with care. *Effective UNTIL July 1, 2001.*	HCSC/HMO Reference
		RCW 48.43.095(1)(h)
3	The Company maintains a fully operational, comprehensive grievance process. *Effective July 1, 2001.*	HCSC/HMO Reference
		RCW 48.43.530
4	The Company provides enrollees access to independent review services to resolve disputes. *Effective July 1, 2001.*	HCSC/HMO Reference
		RCW 48.43.535
6	The Company complies with procedures for health care service review decisions. *Effective December 30, 1999.*	HCSC/HMO Reference
		WAC 284-43-620

The following Complaint Standard failed:

#	Complaint Standard	Reference
5	Response to communications from the OIC must be within 15 business days of receipt of the correspondence. The response must contain the substantial information requested by the OIC.	HCSC/HMO Reference
		WAC 284-30-650, Technical Advisory T 98-4

Complaint Standard #5:

The examiners reviewed the OIC complaints to determine the length of time from receipt by the Companies to response to the OIC. The average response time to the OIC was 10 days. However, in five (5) of the files reviewed, the Companies failed to respond to the OIC within 15 business days of receipt of the complaint.

See Appendix 2.

AGENT ACTIVITY

There were 1,203 licensed and appointed agents of the Companies during the examination period. Seventy three (73) are employees of the Companies. Information provided by the Companies is consistent with records maintained by the OIC.

The Licensing and Appointment Administration Unit (LAAU) in Houston, Texas processes agent licenses and appointments for all Aetna affiliate companies. The Companies provided the examiners with a copy of procedures for agent licensing and appointment. The procedures

accurately describe Washington State licensing and appointment requirements. The procedures instruct staff to query the Companies' Producer Administration Information System (PAIS) to confirm agent licensing and appointment prior to business being conducted. If the agent does not appear in the Companies' PAIS system, the procedures instruct staff how to begin the licensing and/or appointment process.

The examiners reviewed records for 160 agents. Licensing and appointment records for 45 agents that wrote new and renewal business were reviewed. Licensing and appointment records for 42 agents that received quotes were reviewed. Licensing records for all 73 marketing personnel were reviewed. Agent licensing and appointment dates were compared to the dates new business, renewal business and quotes were provided to the agent. The agent licensing and appointment dates for the marketing personnel were compared to the dates of employment.

The examiners found that many marketing personnel were not licensed and/or appointed with the appropriate company at the time of hire to their marketing department position. Procedures for employment indicate that the employee has 60 days to be licensed and/or appointed. The Company indicated during the examination process that new hires were not allowed to perform sales/solicitation functions during the initial 60 days or until the license/appointment date, whichever came first. The examiners found that the Companies did not adhere to this requirement and in some cases the employees were not licensed or appointed for years after their marketing department hire date.

The examiners also noted that a substantial number of employees were appointed with HCSC on 7/8/99. When asked, the Company stated that about this time period, the licensing function was centralized in the Texas office. As part of this change, licensing records were reviewed and those that had not been appointed with HCSC were appointed at that time. The results of the review indicate that a number of violations occurred, but the number significantly decreased once the licensing function was centralized. The other significant event during this timeframe was the acquisition of the Prudential Healthcare business which increased the number of existing staff that were involved in HCSC sales.

The files reviewed consisted of the following:

Source	Total Files	Number Examined
New/Inforce Business	1,792	45
Quotes (7/1/01 through 12/31/01)	633	42
Marketing Personnel	73	73
Total	**2,492**	**160**

Findings

Note: In reviewing agent licensing records, the OIC has established a zero tolerance. If there are any instances of an agent soliciting business prior to obtaining a valid agent license and a valid appointment, the Companies will fail the applicable standard(s).

The following Agent Activity Standard passed without comment:

#	Agent Activity Standard	Reference
3	**The Company must provide the agent with written notice of termination of appointment and send a copy to the OIC.**	**HCSC/HMO Reference** RCW 48.17.160(3)

The following Agent Activity Standards failed:

#	Agent Activity Standard	Reference
1	**The Company requires that agents and brokers are licensed for the appropriate line of business with the State of Washington prior to allowing them to solicit business or represent the Company in any way.**	**HCSC Reference** RCW 48.17.060(1), RCW 48.17.060(2), RCW 48.44.011(2) **HMO Reference** RCW 48.17.060(1), RCW 48.17.060(2), RCW 48.46.023(2)
2	**The Company ensures that agents are appointed to represent the Company prior to allowing them to solicit business on behalf of the Company.**	**HCSC Reference** RCW 48.17.160(1), RCW 48.44.011(2) **HMO Reference** RCW 48.17.160(1), RCW 48.46.023(2)

Agent Activity Standard #1:

- One (1) agent that was not licensed was issued a quote for HCSC products.
- Three (3) agents that were not licensed at the time of sale are shown as the writing agent on three (3) new HMO business cases.
- Six (6) agents that were not licensed were issued quotes for HMO products.
- There were 30 marketing employees who were not licensed within 60 days of the start date of their marketing position with the Companies.

See Appendix 3.

Agent Activity Standard #2:

- Two (2) agents that were not appointed at the time of sale are shown as the writing agent on two (2) new HMO business cases.

- Three (3) agents that were not appointed to represent HCSC were issued quotes for HCSC products.
- Four (4) agents that were not appointed to represent HMO were issued quotes for HMO products.
- Fifty two (52) marketing employees were not appointed to represent HCSC within the first 60 days of being hired as a marketing department employee.
- Forty five (45) marketing employees were not appointed to represent HMO within the first 60 days of being hired as a marketing department employee.

See Appendix 3 & 4.

RATE AND FORM FILING

Companies are required to file rates and forms with the OIC prior to use. HCSC and HMO provided the examiners with copies of large and small group rate filings for 2000 and 2001 for review.

In conjunction with the Underwriting Section of the exam, random samples of new and renewal business and quotes were selected from the Companies' inforce group files and quote log. The Companies had 1,792 inforce groups that were written or renewed during the examination period. A random sample of 50 new and renewal business files was selected for review from this population. The Companies also provided the examiners with their quote logs for the period July 1, 2001 through December 31, 2001. During this time period, 633 quotes were issued. A random sample of 50 files was selected from this population. Random samples were selected based on NAIC Market Conduct Examiners Handbook sampling guidelines.

The rate and form filing review consists of:

- Review of rates charged and quoted to groups to ensure that the rates and factors filed with the OIC were used to determine premium.
- Review of the file to ensure that the benefits requested were the benefits quoted and/or sold.

New and Renewal Business Sample

The following files were removed from the random new and renewal business sample of 50 files:

- One (1) file was quoted outside the examination period and was removed from the random sample of 50 files.
- Two (2) files provided by the Companies did not contain any rate information. The Companies were unable to produce that information when requested. Additionally, one

(1) file could not be located. Discussion concerning these files is found on page 10 under General Examination Findings.

In the remaining 46 files, the Companies provided the examiners with files containing the following sold rates:

Year	HCSC	HMO	Total
2000	5	37	42
2001	3	37	40
TOTAL	**8**	**74**	**82**

Quote Sample

The following files were removed from the random quote sample of 50 files:

- Three (3) files were outside the examination period.
- One (1) file was a duplicate of another within the sample.

In the remaining 46 files, 16 of the groups within the sample received two or more quotes illustrating different plan designs. A total of 64 quotes were reviewed.

Findings

The following Rate and Form Filing Standards passed without comment:

#	Rate and Form Filing Standard	Reference
1	**All contract forms have been filed with the Office of Insurance Commissioner prior to use.**	**HCSC Reference**
		RCW 48.44.040, WAC 284-43-920
		HMO Reference
		RCW 48.46.037(7)(g) and (h), WAC 284-43-920
3	**All contract forms and rates have been filed with the Office of Insurance Commissioner on transmittal forms prescribed by and available from the OIC.**	**HCSC/HMO Reference**
		WAC 284-43-925

The following Rate and Form Filing Standard passed with comment:

#	Rate and Form Filing Standard	Reference
2		**HCSC Reference**

#	Rate and Form Filing Standard	Reference
	All rates have been filed with the Office of Insurance Commissioner prior to use.	RCW 48.44.040, WAC 284-43-920
		HMO Reference
		RCW 48.46.062(2)and (3), WAC 284-43-920

Rate and Form Filing Standard #2:

In reviewing the quotes and renewals for both HCSC and HMO files, the examiners noticed that in all cases for 2001, they were not able to duplicate manually the rates that had been charged to the groups. Discussing this with the Companies, the examiners found that there had been a problem with rate filings for both entities.

When the 2001 rates were filed, the Companies submitted to the OIC large group age and sex discriminate rates instead of the small group non-discriminate rates. This was an inadvertent error on the part of the Companies. The filings were approved by the OIC as submitted. The Companies used the correct, non-discriminate small group rates for all quotes and renewals during 2001. However, the correct rates were not the filed rates and when the examiners tried to match the actual charged and quoted rates to the filing, they were unable to do so. When the correct rates were given to the examiners, they were able to duplicate the quoted and charged rates.

UNDERWRITING

Underwriting Manuals

The Companies provided the examiners with two (2) copies of their Western Region Underwriting Guidelines that were in use during the examination period. The versions are dated January 2000 and March 2001.

The guidelines outline the Companies' policy for the following:

- Participating requirements
- Contribution requirements
- Plan availability based on location and group size
- Domestic partner coverage
- Out-of-area employee and dependent coverage

The policies and requirements described in the guidelines are accurate and concise.

Underwriting Process

The underwriting process for Washington business begins in the Companies' sales and marketing department in Seattle, Washington. After a group has accepted quoted rates, an employer application form and employee enrollment forms are completed by the group and its employees. The group is also asked to provide copies of its business license, copy of prior carrier's billing, and payment for the first month's premium. The materials are returned to the account representative who reviews the information to assure that it is complete and forwards it to the Companies' San Ramon, California location.

Underwriting staff in San Ramon verify that the information included in the enrollment packet is consistent with the information provided when the quote was issued. Underwriters confirm the benefits and rates applied for, compare enrollment applications to the census data used in the quote, and assure that participating and contribution requirements are met. If the group meets the underwriting requirements and is accepted for coverage, the group is added to the Companies' computer system. A group agreement, certificates of coverage and enrollee identification cards are prepared. The completed enrollment materials are forwarded to the Seattle sales associate for delivery to the group.

Underwriting File Review

In conjunction with the Rates and Forms Section of the exam, random samples of new and renewal group files and quote files were selected from the Companies' inforce group files and quote log. The Companies had 1,792 groups in force during the examination period. A random sample of 50 was selected for review. The Companies also provided the examiners with the quote log for the period July 1, 2001 through December 31, 2001 which contained 633 quotes. A random sample of 50 files was selected from this population. The total sample included 100 files.

After initial examination, the examiners determined that several files were to be excluded from the sample:

- One (1) file from the inforce policy sample was outside the scope of the examination period.
- Three (3) quote files were outside the examination period.
- One (1) quote file was a duplicate of another within the sample.

Because many of the files crossed policy years, the examiners reviewed the file for multiple years.

The examiners reviewed the files to assure:

- Rates and benefits were appropriate to group demographics.
- Waiting periods for preexisting conditions were correctly applied and credited based on the size of the group.

- Members of groups were not unfairly denied coverage.
- Notifications of renewal action or termination were provided timely.
- The Companies' underwriting procedures and guidelines were applied consistently throughout the sample.

Findings

The following Underwriting Standards passed without comment:

#	Underwriting Standard	Reference
1	The Company allows a non-custodial parent to enroll a child under family coverage even if the child resides outside the company's normal service area.	HCSC/HMO Reference RCW 48.01.235
2	The Company appropriately reduces preexisting condition exclusions, limitations, or waiting periods in its large group, small group and individual plans by applying time covered by preceding health plan coverage.	HCSC/HMO Reference RCW 48.43.015, WAC 284-43-710
3	The Company may not reject an individual for health plan coverage in a large or small group based upon preexisting conditions of the individual. The Company may not deny, exclude, or limit coverage for an individual's preexisting health conditions. The Company shall accept any state resident within the group and within the Company's service area.	HCSC/HMO Reference RCW 48.43.025, RCW 48.43.035(1), WAC 284-43-720
4	Eligibility to purchase a health benefit plan must be extended to all small employers and small groups as defined in RCW 48.43.005(24).	HCSC/HMO Reference RCW 48.43.028
5	Dependent children cannot be terminated from an individual or group plan because of developmental disability or physical handicap.	HCSC Reference RCW 48.44.200, RCW 48.44.210 HMO Reference RCW 48.46.320
6	All plans shall cover newborn infants with congenital anomalies from the moment of birth.	HCSC Reference RCW 48.44.212(1) HMO Reference RCW 48.46.250(1)
7	No plan may deny coverage solely on account of race, religion, national origin, or the presence of any sensory, mental, or physical handicap.	HCSC Reference RCW 48.44.220 HMO Reference RCW 48.46.060(5), RCW 48.46.370
8		HCSC Reference

#	Underwriting Standard	Reference
	The Company may not refuse, cancel, or decline coverage solely because of a mastectomy or lumpectomy more than five (5) years prior.	RCW 48.44.335
		HMO Reference
		RCW 48.46.285
9	All plans cover newborns from the moment of birth and adoptive children from the moment of placement, and that notification to the company and payment of premium requirements be no less than 60 days.	HCSC Reference
		RCW 48.44.420, RCW 48.44.212
		HMO Reference
		RCW 48.46.490, RCW 48.46.250

CONTRACTS AND MEMBER HANDBOOKS

The examiners reviewed the Companies' 2001 large group contract filing and small group contract filing during the examination period. The master contracts reviewed were filed October 24, 2001 for a retroactive effective date of July 1, 2001. Each master contract was approved by the OIC on May 6, 2002. As required by WAC 284-43-920(1)(b), the 2001 filings were submitted to satisfy the 18-month filing requirement. In addition to reviewing the master contract filings, the examiners reviewed one (1) HCSC certificate of coverage issued to a small group and one (1) HMO certificate of coverage issued to a large group. These documents were reviewed to assure that the contracts and certificates of coverage issued to these groups did not contain any alterations from the filed and approved master contracts and certificates of coverage.

Findings

The following Contract and Member Handbooks Standards passed without comment:

#	Contract and Member Handbooks Standard	Reference
2	All contracts must include exercise of conscience provisions.	HCSC/HMO Reference
		RCW 48.43.065, WAC 284-43-800
3	Enrollees are not prohibited from contracting for services outside the plan.	HCSC/HMO Reference
		RCW 48.43.085
4	Enrollees are allowed to contract for mental health services at enrollee's expense.	HCSC/HMO Reference
		RCW 48.43.087
6	Decisions concerning maternity care and services are to be made between the mother and the provider.	HCSC/HMO Reference
		RCW 48.43.115
7	An enrollee may receive benefits at a long term care facility if he/she was a resident prior to hospitalization.	HCSC/HMO Reference
		RCW 48.43.125
8	All plans must allow enrollees to select a primary care provider who is accepting new patients from a list of participating providers.	HCSC/HMO Reference
		RCW 48.43.515, WAC 284-43-251

#	Contract and Member Handbooks Standard	Reference
9	All plans must include coverage for diabetes.	HCSC Reference
		RCW 48.44.315
		HMO Reference
		RCW 48.46.272
11	All plans must include coverage for reconstructive breast surgery.	HCSC Reference
		RCW 48.44.330
		HMO Reference
		RCW 48.46.280
12	All plans shall waive preauthorization for mental health treatment if member is involuntarily committed to a state mental hospital.	HCSC Reference
		RCW 48.44.342
		HMO Reference
		RCW 48.46.292
13	All plans must include provisions to assure that dependents shall have the right to continue coverage in the event of loss of eligibility by the principal enrollee.	HCSC Reference
		RCW 48.44.400
		HMO Reference
		RCW 48.46.480
14	All plans must provide coverage for the formula necessary for the treatment of phenylketonuria (PKU).	HCSC Reference
		RCW 48.44.440, WAC 284-44-450
		HMO Reference
		RCW 48.46.510, WAC 284-46-100
15	All plans shall offer optional coverage for the treatment of temporomandibular joint disorders (TMJ).	HCSC Reference
		RCW 48.44.460, WAC 284-44-042
		HMO Reference
		RCW 48.46.530, WAC 284-46-506
16	All group plans must contain, or incorporate by endorsement, provisions guaranteeing continuity of coverage.	HCSC/HMO Reference
		RCW 48.43.035(2), WAC 284-43-730(1)
17	All plans that include pharmacy services coverage must include the required disclosure statement. *Effective July 1, 2001.*	HCSC/HMO Reference
		WAC 284-43-815
18	All plans must offer substitution of home health care in lieu of hospitalization or institutionalization.	HCSC Reference
		RCW 48.44.320, WAC 284-44-500
		HMO Reference
		WAC 284-46-500

#	Contract and Member Handbooks Standard	Reference
19	All plans that exclude or limit experimental and investigational prescriptions, treatments, services, or procedures must include a definition of experimental and investigational.	HCSC Reference WAC 284-44-043 HMO Reference WAC 284-46-507
20	If the health plan contains provisions for the reduction of benefits, the provisions shall comply with the Standards for Coordinate of Benefits.	HCSC/HMO Reference Chapter 284-51 WAC
21	All group plans must offer supplemental coverage for mental health treatment. If mental health treatment is included, the specified statement as defined must be included in the contract.	HCSC Reference RCW 48.44.340, WAC 284-43-810 HMO Reference RCW 48.46.290, WAC 284-43-810
22	All group plans shall provide benefits for the treatment of chemical dependency. All contract benefits for the treatment of chemical dependency must comply with the specified standards.	HCSC Reference RCW 48.44.240, Chapter 284-53 WAC HMO Reference RCW 48.46.350, Chapter 284-53 WAC
24	All group plans must provide benefits for prenatal diagnosis of congenital disorders.	HCSC Reference RCW 48.44.344 HMO Reference RCW 48.46.375
26	All group plans must include a provision granting a person covered by the plan the right to obtain a conversion agreement upon termination of the person's eligibility.	HCSC Reference RCW 48.44.370, Chapter 284-52 WAC HMO Reference RCW 48.46.450, Chapter 284-52 WAC
27	All group plans must provide coverage for neurodevelopmental therapies for individuals age 6 and under.	HCSC Reference RCW 48.44.450 HMO Reference RCW 48.46.520
28	Every health care service contract shall conform to the prescribed format standards and contain the prescribed contract standards.	HCSC Reference WAC 284-44-030, WAC 284-44-040 HMO Reference None
29	All plans offered by a health care service contractor shall	HCSC Reference

#	Contract and Member Handbooks Standard	Reference
	contain provisions stating that the services received by a registered nurse or advanced registered nurse practitioner will not be denied.	WAC 284-44-045
		HMO Reference
		None
30	All health care service contractor group plans shall offer coverage for chiropractic care on the same basis as any other care.	HCSC Reference
		RCW 48.44.310(1)
		HMO Reference
		None
31	A health care service contractor shall produce and provide certificates of coverage to the employer for distribution to each covered employee.	HCSC Reference
		WAC 284-44-050
		HMO Reference
		None

The following Contract and Member Handbooks Standards passed with comment:

#	Contract and Member Handbooks Standard	Reference
1	All plans must provide female enrollees direct access to women's health care services.	HCSC/HMO Reference
		RCW 48.42.100, WAC 284-43-250
5	All plans shall cover emergency services necessary to screen and stabilize a covered person.	HCSC/HMO Reference
		RCW 48.43.093
10	All plans must include coverage for mammograms.	HCSC Reference
		RCW 48.44.325, WAC 284-44-046
		HMO Reference
		RCW 48.46.275
23	An enrollee may pay premium directly to the health carrier in the event of a labor dispute.	HCSC Reference
		RCW 48.44.250
		HMO Reference
		RCW 48.46.360
25	All group plans must include an offer to include an optional continuation provision.	HCSC Reference
		RCW 48.44.360
		HMO Reference
		RCW 48.46.440

Contract and Member Handbooks Standards #1 and #10:

There is language in the contracts implying mammograms are only covered when ordered by the member's PCP or women's health care specialist. This language suggests that authorization is required for mammograms.

Subsequent Event: The Companies will change the language in future filings to read "...Mammograms, by a participating provider, when recommended by the member's PCP or women's health care specialist."

Contract and Member Handbook Standard #1:

There is language in the contracts implying that emergency care is available only until a primary care physician (PCP) is selected. The statement is limiting and does not account for direct access benefits that do not require PCP direction or referral.

Subsequent Event: The Companies have agreed to amend contract language in future filings to read "Until a PCP is selected, benefits will be limited to coverage for medical emergency care and to certain direct access specialist benefits as described in this certificate."

Contract and Member Handbooks Standard #5:

In the section about emergency care and urgent care benefits, the certificates of coverage state that "...a member must receive followup care either from the PCP or care must be arranged by the PCP. If this procedure is not followed, member will be responsible for payment of all services received." The statement in the certificates of coverage implies that the emergency care or urgent care visit would also be denied.

Subsequent Event: The Companies have agreed to amend future filings to read "The member must follow this procedure, or the member will be responsible for payment of all followup services received."

Contract and Member Handbooks Standard #23:

The contract section concerning continuation of coverage during a labor dispute contained language implying that rates may be changed arbitrarily.

Subsequent Event: The Companies have agreed to amend contract language in future filings to read "If the Premium paid by the Subscriber's employer increases during the time the Subscriber is continuing coverage under this section, the Subscriber's premiums will increase by the same amount."

Contract and Member Handbooks Standard #25:

The certificates of coverage state that "Continuation coverage may occur without payment for a period equal to one month for each year that Subscriber was covered to a maximum of three months." This statement conflicted with another section stating that continuation coverage is available for up to three (3) months upon the payment of premium. When questioned about this

discrepancy, the Companies responded "If the contract does not have the continuation provision, the language would not appear in the certificate of coverage. The coverage is free only if the member qualifies for coverage without payment of premium."

Subsequent Event: To avoid confusion, the Companies have agreed to amend contract language in future filings to read "Continuation of coverage for up to three (3) months without payment of additional premium as specified in item B will apply to the extent that the member is eligible for the benefit."

PROVIDER CONTRACTS

Provider Manuals

The Companies maintain a Participating Physician Procedure Manual and a Hospital Procedure Manual. The manuals are updated every two (2) years. The examiners reviewed both manuals. These manuals are used by providers who are contracted with both HCSC and HMO. The Companies confirmed to the examiners that the manuals provided were published in 2000 and that there were no updates to the manuals in 2000 or 2001.

The examiners found incorrect and conflicting information in the Participating Physician Procedure Manual regarding coordination of benefits (COB) provisions. The manual contained two (2) information sheets titled Facts about Coordination of Benefits for Members, dated January 1998 and November 2000. The January 1998 information states:

> "...you must stay within the Aetna US Healthcare network of participating providers for benefits to be extended by Aetna US Healthcare as a secondary payor for all covered services."

The November 2000 information states:

> "...to maximize your benefits it is best to stay within the Aetna US Healthcare network of participating providers for benefits."

The examiners also found incorrect information regarding COB in the Hospital Procedure Manual. It stated:

> "...depending on the COB provision in the plan, the balance will be processed up to 100 percent of the Aetna US Healthcare allowable, but no more than the normal plan benefits available."

WAC 284-51-050(3) through (8) requires that the Companies coordinate benefits for covered services based on no less than the primary plan's "usual, customary and reasonable" charge for health care services or supplies when the Companies are paying as secondary carrier. Additionally, when paying as secondary carrier, the Companies may not restrict a member to obtaining services from its network of participating providers in order for benefits to be coordinated for covered services. The examiners did not find evidence that COB claims were mishandled as a result of this misinformation.

Provider Directories

The examiners reviewed 12 provider directories in use during the examination period. The directories were for the Companies' HCSC, HMO, and Basic Health/Healthy Options plans.

Two sections of the provider manual contain language that could be misleading to members. In the section titled Direct Access to Women's Health Care Specialists, the directory states that female members "may self-refer to Women's Health Care Specialists, including physicians who specialize in women's health care. ARNP nurse midwives, Licensed Midwives, ARNPs and PAs who specialize in women's health care for women's health care services including maternity." This ambiguous language implies that a member may seek treatment from any provider without regard to the Companies' networks. This is not the case, and if a member is treated by a provider outside the network, the claim is denied. After discussions with the Companies, they agreed to change this language.

The other area of concern to the examiners is a disclaimer in the Notice to Members section of the provider directory. The disclaimer states that members need to check the Companies' web site for the most current plan information and provider information. This language appears to assume that all members have access to the web site and does not mention other means available for members to obtained updated plan and provider information.

Provider Contract Review

The Companies contract with individual providers and provider organizations. The provider organizations maintain their own contracts with individual hospital(s), PCPs, specialists, and ancillary providers. Provider contracting responsibilities are handled in the Seattle, Washington location and the San Ramon, California location. When a provider is granted a contract, the contract is for both the HCSC plans and HMO plans.

The Companies used 44 provider contract forms during the examination period. The examiners were provided with four (4) generic contract forms. These forms were compared to the information on the OIC mainframe system. It was discovered that the Companies had filed an additional 26 generic contract forms during the examination period. A random sample of 59 specific provider contracts was selected for review from the Companies' QPOS/USAccess directory (1/00) and HMO/Aetna Open Access directory (7/01). During review of the specific provider contract sample, the examiners discovered 14 provider contract forms filed prior to the examination period were still in use.

The Companies do not maintain an adequate followup procedure with its providers in regard to contract execution. In the random sample of 59 specific provider contracts, it took between two months and 20 months for 22 of the contracts to be properly executed and countersigned.

The following Provider Contract Standards passed without comment:

#	Provider Contract Standard	Reference
1	No individual health care provider may be required	HCSC/HMO Reference

#	Provider Contract Standard	Reference
	by law or contract in any circumstances to participate in the provision of a specific service if they object to so doing for reason of conscience or religion.	RCW 48.43.065(2)(a)
4	Provider contracts shall contain provisions obligating the provider to provide services for the duration of the period after an HCSC's/HMO's insolvency for which premium payment has been made and until the enrolled participant's discharge from inpatient facilities.	HCSC Reference RCW 48.44.055(2) HMO Reference RCW 48.46.245(2)
5	An HMO may not discriminate against a qualified doctor of osteopathic medicine and surgery solely because that practitioner was board certified or eligible under an approved osteopathic certifying board instead of under an approved medical certifying board.	HCSC Reference None HMO Reference RCW 48.46.575
8	All plans must include every category of provider.	HCSC/HMO Reference WAC 284-43-205 RCW 48.43.045

The following Provider Contract Standard passed with comment:

#	Provider Contract Standard	Reference
2	All provider contracts shall contain language holding the enrolled participant harmless should the Company fail to pay for health care services.	HCSC Reference RCW 48.44.020(4), WAC 284-43-320(2) HMO Reference RCW 48.46.243(1) and (4) WAC 284-43-320(2)
3	All provider contract forms must be filed with and approved by the OIC prior to use.	HCSC Reference RCW 48.44.070, WAC 284-43-330 HMO Reference RCW 48.46.243(3), WAC 284-43-330

Provider Contract Standard #2:

Ten (10) of the 44 contracts in use contain the following statement in Section 3.2.1 of the contract:

> "If the applicable Payor is not a Health Maintenance Organization or a Health Care Service Contractor, Provider may bill a Member for Covered Services provided to the Member in the event that the Payor becomes insolvent or otherwise breaches the terms and conditions of its agreement to pay, provided that: (a) Contractor shall have first exhausted all reasonable efforts to obtain payment from the Payor, and (b) contractor shall not institute or maintain any collection activities or proceed with any action at law or in equity against a Member to collect any sums that are owed by a Payor to Contractor unless Contractor provides at least thirty (30) days prior notice to Company of contractor intent to institute such an action."

This statement is in violation of hold harmless and insolvency provisions found in WAC 284-43-320. However, the contracts were approved by the OIC as submitted. When questioned about this language, the Companies responded "Provider contracts encompass all of our plans, including self-insured plans. Section 3.2.1 is intended to apply to self-insured plans which are not subject to OIC regulation..."

See Appendix 5.

Subsequent Event: The Companies have drafted an amendment to be attached to its existing provider contracts to meet compliance requirements. The amendment was received by the OIC on November 13, 2002, with a requested effective date of December 2, 2002. The amendment was approved by the OIC's Rates and Forms Division on December 20, 2002.

Provider Contract Standard #3:

The examiners found one (1) contract in use that had not been filed with the OIC as required by RCW 48.46.243(3) and WAC 284-43-330(1) and (2). The contract with Virginia Mason Medical Center has not been filed. The contract presented to the examiners for review did not include an effective date and it was not countersigned by the Companies.

See Appendix 6.

The following Provider Contract Standards failed:

#	Provider Contract Standard	Reference
6	**All provider contract forms must contain and adhere to the prescribed standards.**	**HCSC/HMO Reference** **WAC 284-43-320 through WAC 284-43-340**

#	Provider Contract Standard	Reference
7	The definition of emergency medical condition must comply with required definitions.	HCSC/HMO Reference RCW 48.43.005(11), WAC 284-43-130(6)

Provider Contract Standard #6:

The Companies were unable to produce copies of three (3) of the requested sample files. WAC 284-43-330(4) states that "...the health carrier shall have access to all contracts and provide copies to facilitate regulatory review..." Discussion concerning the Companies' inability to produce requested documentation was presented previously in the Company Operations and Management Section of this report (page 10).

During review of the specific provider contracts, the examiners found that the Companies have failed to use filed and approved contracts that incorporate the contract standards defined in WAC 284-43-320 through WAC 284-43-340. Fifty-seven (57) of the 59 files (96.6%) reviewed in the random sample failed to comply with WAC 284-43-331(1) and WAC 284-43-331(2). WAC 284-43-331(1) states "All participating provider and facility contracts entered into after the effective date of these rules shall comply with these rules no later than July 1, 2000." WAC 284-43-331(2) states "Participating provider and facility contracts entered into prior to the effective date of these rules shall be amended upon renewal to comply with these rules and all such contracts shall conform to these provisions no later than January 1, 2001."

The examiners asked the Companies to provide an explanation regarding the existence of provider contract forms that comply with prescribed standards and why these contracts were not in use. Personnel of the Companies responded that, in an attempt to avoid provider reimbursement negotiations, updated specific provider contract forms were not issued to its providers until renewal of each specific contract.

Subsequent Event: The Companies have drafted an amendment to be attached to its existing provider contracts to meet compliance requirements. The amendment was received by the OIC on November 13, 2002, with a requested effective date of December 2, 2002. The amendment was approved by the OIC's Rates and Forms Division on December 20, 2002.

The examiners asked to review the Companies contract with Magellan Behavioral Health Inc. The Companies produced a contract between HMO and Human Affairs International Inc. (HAI) executed in 1998. In 1999, HAI was sold by Aetna to Magellan Behavioral Health Inc. This contract has never been amended to reflect the name change to Magellan Behavioral Health Inc. Additionally, we were not able to find any amendments to this contract subsequent to the Companies' name changes. When asked about this, the Companies stated that they are now going to get an amendment showing the name change(s) subsequent to this examination.

The examiners also found that the contract is not in compliance with WAC 284-43-331. When asked why this contract has not been re-filed to be in compliance with this regulation, the Companies stated that they were unaware that the contract is non-compliant and were unaware of the need to re-file the contract. The Companies also stated that because the current contract with Magellan will not terminate until January 2004, they will not pursue executing a new contract until that date.

Subsequent Event: In early 2003, the Companies submitted contract forms between the providers and Magellan to the OIC for approval. During that review, the Companies were advised that a new contract must be filed between the Companies and Magellan.

Therefore, the contract that is currently in effect between the Companies and Magellan does not conform to the requirements of WAC 284-43-300 through WAC 284-43-340, especially WAC 284-43-331(2) which states that provider contracts that were in effect prior to the effective date of November 11, 1999 must be amended to conform no later than January 1, 2001. This contract is in violation of this rule. See Appendix 7.

Provider Contract Standard #7:

The examiners found 13 of the 44 provider contract forms in use failed to have the correct definition of emergency medical condition. See Appendix 8.

CLAIMS

Claim Processing Manual

The Companies provided the examiners their general procedures manual. The manual provided a description of workflow in the claims department. The examiners found the manual to accurately describe the processes in place.

Claims Processing

Electronic and paper claims are sent to the Companies' offices in Blue Bell, Pennsylvania. Claims are adjudicated in the Companies' Fresno, California location. Electronic claims are submitted to a clearinghouse system which in turn transmits them to the Companies' gateway. The gateway sorts the electronic claims for processing. When paper claims are received by the Companies' offices in Blue Bell, Pennsylvania, they are scanned. Data entry clerks receive the imaged claims and key member, provider and billing information into the claims system.

The Companies' claims system was created in 1987. It has been through several upgrades with the most recent upgrade occurring in November 2002. The latest upgrade allows storage of more than four (4) line items per claim on one (1) record.

Forty (40) percent of the claims received by the Companies are auto-adjudicated. The claims system automatically makes all payment calculations, and tracks copayments, deductibles, out-of-pocket maximums, benefit level maximums (visits and/or dollars), and coordination of benefits savings.

Claim processors perform manual claims adjudication for non-standard claim forms sent as paper claims, UB92s except for emergency claims, and pended claims that could not be resolved by auto adjudication. Processors verify key claim elements and complete and correct missing or invalid information. Once the processor has completed the claim, it is released for payment.

The payment processing system generates payments and payment reports on a daily basis. The system produces checks, drafts, explanations of provider payments, explanations of benefits for members, and explanations of electronic remittance. The payment processing system is also programmed to include interest payments that may become due should a clean claim not be paid or denied as required.

Internal Claims Auditing

The Quality Audit Unit audits samples of claims prior to release on a daily basis in order to determine processing and payment accuracy. Both manually processed claims and auto adjudicated claims are selected. Quality results are tracked at both the individual processor and processing unit level. Results are reported to management weekly.

In addition, the Companies produce several reports on a periodic basis in order to monitor and facilitate decisions about claim production, staffing and work allocation. The reports are discussed with claims leaders and claim team coordinators to identify best practices, shortcomings, and possible areas of improvement. The examiners reviewed the claims quality reports for November 2000 and November 2001. The findings in the internal audits were consistent with the examiners' findings in the review of the random sample. The errors noted in the claims quality reports were processor errors. The Companies' claims leaders and claim team coordinators take appropriate counseling action as required.

Claims Review

The Companies processed 68,040 claims in 2000 and 59,426 claims in 2001. The examiners reviewed 216 claims that were randomly selected from the population. Because of the number of claims available in the total population, the examiners requested that the Companies randomly select the claim files to be reviewed. The Companies provided the examiners with a sample of 216 claims. The claims in the sample were selected using a skip interval formula. A random number was selected, and the sample was generated by sequentially going through the total population of claims.

Findings

The examiners noted errors on six (6) claims in the randomly selected sample:

- Two (2) claims were system adjudicated under the wrong family member. The Companies corrected these claims while the examiners were onsite. The examiners verified the corrections online and via screen prints.
- One (1) claim was for women's direct access services and the member was identified as a male. Gender identification was corrected while the examiners were onsite and verified online and via screen print provided to the examiners.
- One (1) file was missing from the sample. After 18 months, claims residing on the system are archived. This file could not be retrieved and the Companies could provide no explanation.
- One (1) claim had an incorrect date of service keyed on a line item. The year that the services were received was keyed incorrectly.
- One (1) claim had several line items. The claim was separated and a claim number was assigned to each line item. The Companies could not provide an explanation regarding the processing of this claim.

The following Claims Standards passed without comment:

#	Claims Standard	Reference
1	**The Company shall provide no less than urgent and emergent care to a child who does not reside in the Company's service area.**	**HCSC/HMO Reference** RCW 48.01.235(3)
2	**The Company shall not retrospectively deny emergency or nonemergency care that had prior authorization.** ***Effective July 1, 2001.***	**HCSC/HMO Reference** RCW 48.43.525(1)
3	**The Company shall not retrospectively deny an individual prescription drug claim that had prior authorization.**	**HCSC Reference** RCW 48.44.465 **HMO Reference** RCW 48.46.535
4	**The Company shall not deny benefits for any service performed by a denturist if the service performed was within the lawful scope of such person's license, and the agreement would have provided benefit if services were performed by a dentist.**	**HCSC Reference** RCW 48.43.180, RCW 48.44.500 **HMO Reference** RCW 48.43.180, RCW 48.46.570
5	**The Company shall pay or deny 95% of all claims within sixty (60) days of receipt.** ***Effective November 11, 1999.***	**HCSC/HMO Reference** WAC 284-43-321(2)
6		**HCSC/HMO Reference**

#	Claims Standard	Reference
	The denial of any claim must be communicated to the provider or facility with the specific reason the claim was denied.	WAC 284-43-321(4)
7	The Company maintains a documented utilization review program with descriptions and conducts utilization review within the prescribed format defined.	HCSC/HMO Reference RCW 48.43.520, WAC 284-43-410
8	The Company administers Coordination of Benefits provisions as required.	HCSC/HMO Reference Chapter 284-51 WAC

INSTRUCTIONS

	INSTRUCTION	PAGE #
1	The Companies are instructed to submit copies of any changes to its registration documents to the OIC. Reference: RCW 48.44.013, RCW 48.46.012.	8
2	The Companies are instructed to assure that the composition of its Board of Directors allows meaningful representation from its enrolled participants. Reference: RCW 48.46.030(2), RCW 48.46.070.	8
3	The Companies are instructed to facilitate future examinations by providing accurate, meaningful information and timely responses to the examiners. Reference: RCW 48.03.030(1), RCW 48.44.145(2), RCW 46.46.120(2).	9
4	The Companies are instructed to respond to communications from the OIC within 15 business days of receipt of inquiry. Responses to the OIC shall contain the substantial information requested by the OIC. Reference: WAC 284-30-650, Technical Advisory T 98-4.	17
5	The Companies are instructed to ensure that agents and brokers are licensed for the appropriate line of business with the State of Washington prior to allowing them to solicit business or represent the Companies in any way. Reference: RCW 48.17.060(1) and (2), RCW 48.44.011(2), RCW 48.46.023(1) and (2).	19
6	The Companies are instructed to ensure that agents are appointed to represent the Companies prior to allowing them to solicit business on behalf of the Companies. Reference: RCW 48.17.160, RCW 48.44.011(2), RCW 48.46.023(1) and (2).	19
7	The Companies are instructed to immediately distribute the provider contract amendment to all of its providers so that each contract contains prescribed standards. Reference: WAC 284-43-320 through WAC 284-43-340.	33
8	The Companies are instructed to immediately implement or withdraw the filed Magellan Behavioral Health contract. Reference: RCW 48.46.243(1), WAC 284-43-320 through WAC 284-43-340.	34
9	The Companies are instructed to include the prescribed definition for emergency medical condition in each of its provider contracts. Reference: RCW 48.43.005(11), WAC 284-43-130(6).	34
10	The Companies must maintain a complete advertising file. Reference: WAC 284-50-200	12
11	The Companies must file rates with the OIC prior to use and must implement the filed rates into its computer quoting systems. Reference: RCW 48.44.040, RCW 48.46.062(2) and (3), WAC 284-43-920.	21
12	The Companies must amend contract language in future filings to clarify the process in regard to mammograms. Reference: RCW 48.42.100, RCW	28

	INSTRUCTION	PAGE #
	48.44.325, RCW 48.46.275, WAC 284-43-250, WAC 284-44-046.	
13	The Companies must amend contract language in future filings to state that both emergency care and direct access benefits are available even if a PCP is not selected. RCW 48.42.100, WAC 284-43-250.	28
14	The Companies must amend contract language in future filings to clarify procedures for follow up treatment to emergency care. Reference: RCW 48.43.093.	28
15	The Companies must amend contract language in future filings to clarify provisions regarding premium payment by the member during a labor dispute. Reference: RCW 48.44.250, RCW 48.46.360.	28
16	The Companies must amend contract language in future filings to clarify provisions concerning continuation of coverage after termination from a group plan. Reference: RCW 48.44.360, RCW 48.46.440.	28
17	The Companies must include hold harmless language in its provider contracts. Reference: RCW 48.44.020(4), RCW 48.46.243(1), RCW 48.46.243(4), WAC 284-43-320(2).	33
18	The Companies must file provider contract forms with the OIC prior to use. Reference: RCW 48.44.070, RCW 48.46.243(3), WAC 284-43-330.	34

RECOMMENDATIONS

	RECOMMENDATIONS	PAGE #
1	It is recommended that the Companies revise their claim processing guidelines to instruct processors to adjudicate non-participating provider claims at rates equal to 100% of the Companies' usual, customary and reasonable amounts.	15
2	It is recommended that the Companies implement followup procedures to assure the member's primary care physician is recorded timely.	15

SUMMARY OF STANDARDS

Company Operations and Management:

#	STANDARD	PAGE	PASS	FAIL
1	The Company is required to be registered with the Office of Insurance Commissioner prior to acting as a health maintenance organization in the State of Washington. RCW 48.44.015(1), Reference: RCW 48.46.027(1).	8	X	
2	The Company is required to report to the OIC any changes to the registration documents, including Articles of Incorporation, Bylaws, and Amendments at the same time as submitting such documents to the Secretary of State. Reference: RCW 48.44.013, RCW 48.46.012.	8		X
3	The Company is governed by a board nominated and elected by the voting members or enrolled participants and providers, and afforded a meaningful role in policy making of the Company. At least one-third of the board shall consist of consumers who are representative of the enrolled population. Reference: RCW 48.46.030(2), RCW 48.46.070.	8		X

General Examination Findings:

#	STANDARD	PAGE	PASS	FAIL
1	The Company does business in good faith, and practices honesty and equity in all transactions. Reference: RCW 48.01.030.	9	X	
2	The Company must facilitate the examination process by providing its accounts, records, documents and files to the examiners upon request. Reference: RCW 48.03.030(1), RCW 48.44.145(2), RCW 48.46.120(2).	9		X
3	The Company may not discourage members from contacting the OIC and may not discriminate against those members that do contact the OIC. Reference: WAC 284-30-572(2).	9	X	

Advertising:

#	STANDARD	PAGE	PASS	FAIL
1	The Company cannot advertise a plan to prevent illness or promote health unless a) the clinical preventive benefits are the same as the basic health plan; b) it monitors and reports annually to enrollees on standards of health care and satisfaction of enrollees; c) makes available its plan to identify and manage the most prevalent diseases within its enrolled population on request. Reference: RCW 48.43.510(5), WAC 284-43-820(5).	11	X	
2	No advertising may contain any false, deceptive or misleading information. Reference: RCW 48.44.110, RCW 48.46.400.	11	X	
3	The Company cannot make misleading comparisons with other companies to induce the consumer to change from another HCSC or HMO. Reference: RCW 48.44.140, RCW 48.46.410.	11	X	
4	The Company complies with the Washington Disability Insurance Advertising Regulations. Reference: WAC 284-50-010 through WAC 284-50-230.	11	X	
5	The Company maintains a complete advertising file. Reference: WAC 284-50-200.	12	X	
6	The Company must comply with all health plan disclosures as required by regulation. Reference: WAC 284-43-820(1) through (3).	11	X	
7	The Company cannot misrepresent the terms, benefits, or advantages of the contract. Reference: RCW 48.44.120, RCW 48.46.060(2) and (3), WAC 284-50-050.	11	X	
8	The Company cannot guarantee future dividends or future refunds except in group contracts with an experience refund provision. Reference: RCW 48.44.130.	12	X	
9	No HMO may use the words "insurance", "casualty", "surety" or "mutual to describe itself in its advertising materials. Reference: RCW 48.46.110(1) and RCW 48.44.090.	12	X	
10	No advertisement can contain any type of endorsement of any state or government agency. Reference: RCW 48.46.310 (WAC 284-50-140).	12	X	

Complaints:

#	STANDARD	PAGE	PASS	FAIL
1	The Company has filed a copy of its procedures for review and adjudication of complaints with the OIC. Reference: RCW 48.43.055, RCW 48.46.100.	16	X	

#	STANDARD	PAGE	PASS	FAIL
2	The Company has a means to disclose to an enrollee or prospective enrollee a copy of the grievance procedures for claims and for service denials as well as dissatisfaction with care. *Effective until July 1, 2001.* Reference: RCW 48.43.095(1)(h)	17	X	
3	The Company maintains a fully operational, comprehensive grievance process. *Effective July 1, 2001.* Reference: RCW 48.43.530.	17	X	
4	The Company provides enrollees access to independent review services to resolve disputes. *Effective July 1, 2001.* Reference: RCW 48.43.535.	17	X	
5	Response to communications from the OIC must be within 15 business days of receipt of the correspondence. The response must contain the substantial information requested by the OIC. Reference: WAC 284-30-650, Technical Advisory T 98-4.	16		X
6	The Company complies with procedures for health care service review decisions. *Effective December 30, 1999.* Reference: WAC 284-43-620.	17	X	

Agent Activity:

#	STANDARD	PAGE	PASS	FAIL
1	The Company ensures that agents and brokers are licensed for the appropriate line of business with the State of Washington prior to allowing them to solicit business or represent the Company in any way. Reference: RCW 48.17.060(1) and (2), RCW 48.44.011(2), RCW 48.46.023(2).	19		X
2	The Company ensures that agents are appointed to represent the Company prior to allowing them to solicit business on behalf of the Company. Reference: RCW 48.17.160, RCW 48.44.011(2), RCW 48.46.023(2).	19		X
3	The Company must provide the agent with written notice of termination of appointment and send a copy to the OIC. Reference: RCW 48.17.160(3).	18	X	

Rate and Form Filing:

#	STANDARD	PAGE	PASS	FAIL
1	All contract forms have been filed with the Office of Insurance Commissioner prior to use. Reference: RCW 48.44.040, RCW 48.46.037(7)(g) and (h), WAC 284-43-920.	21	X	

#	STANDARD	PAGE	PASS	FAIL
2	All rates have been filed with the Office of Insurance Commissioner prior to use. Reference: RCW 48.44.040, RCW 48.46.062(2) and (3), WAC 284-43-920.	21	X	
3	All contract forms and rates have been filed with the Office of Insurance Commissioner on transmittal forms prescribed by and available from the Commissioner. Reference: WAC 284-43-925.	21	X	

Underwriting:

#	STANDARD	PAGE	PASS	FAIL
1	The Company complies with the prescribed requirements for enrollment and coverage of a child under the health plan of the child's parent. Reference: RCW 48.01.235, RCW 48.44.212 and RCW 48.46.250.	23	X	
2	The Company appropriately reduces preexisting condition exclusions, limitations, or waiting periods in its large group, small group and individual plans by applying time covered by the preceding health plan coverage. Reference: RCW 48.43.015, WAC 284-43-710.	24	X	
3	The Company may not reject an individual for health plan coverage in a large or small group based upon preexisting conditions of the individual. The Company may not deny, exclude, or limit coverage for an individual's preexisting health conditions. The Company shall accept any state resident within the group and within the Company's service area. Reference: RCW 48.43.025, RCW 48.43.035(1), WAC 284-43-720.	24	X	
4	Eligibility to purchase a health benefit plan must be extended to all small employers and small groups as defined in RCW 48.43.005(24).	24	X	
5	Dependent children cannot be terminated from an individual or group plan because of developmental disability or physical handicap. Reference: RCW 48.44.200, RCW 48.44.210, RCW 48.46.320.	24	X	
6	All plans shall cover newborn infants and congenital anomalies from the moment of birth. Reference: RCW 48.44.212, RCW 48.46.250.	24	X	
7	No plan may deny coverage solely on account of race, religion, national origin, or the presence of any sensory, mental, or physical handicap. Reference: RCW 48.44.220, RCW 48.46.060(5), RCW 48.46.370.	24	X	

#	STANDARD	PAGE	PASS	FAIL
8	The Company may not refuse, cancel, or decline coverage solely because of a mastectomy or lumpectomy more than five (5) years prior. Reference: RCW 48.44.335, RCW 48.46.285.	24	X	
9	Adoptive children shall be covered on the same basis as other dependents. Reference: RCW 48.44.420, RCW 48.46.490.	24	X	

Contracts and Member Handbooks:

#	STANDARD	PAGE	PASS	FAIL
1	All plans must provide female enrollees direct access to women's health care services. Reference: RCW 48.42.100, WAC 284-43-250.	28	X	
2	All contracts must include exercise of conscience provisions. Reference: RCW 48.43.065, WAC 284-43-800.	25	X	
3	Enrollees are not prohibited from contracting for services outside the plan. Reference: RCW: 48.43.085.	25	X	
4	Enrollees are allowed to contract for mental health services at enrollee's expense. Reference: RCW 48.43.087.	25	X	
5	All plans shall cover emergency services necessary to screen and stabilize a covered person. Reference: RCW 48.43.093	28	X	
6	Decisions concerning maternity care and services are to be made between the mother and the provider. Reference: RCW 48.43.115.	25	X	
7	An enrollee may receive benefits at a long term care facility if he/she was a resident prior to hospitalization. Reference: RCW 48.43.125.	25	X	
8	All plans must allow enrollees to select a primary care provider who is accepting new patients from a list of participating providers. Reference: RCW 48.43.515, WAC 284-43-251.	25	X	
9	All plans must include coverage for diabetes. Reference: RCW 48.44.315, RCW 48.46.272.	25	X	
10	All plans must include coverage for mammograms. Reference: RCW 48.44.325, RCW 48.46.275, WAC 284-44-046.	28	X	
11	All plans must include coverage for reconstructive breast surgery. Reference: RCW 48.44.330, RCW 48.46.280.	25	X	
12	All plans shall waive preauthorization for mental health treatment if member is involuntarily committed to a state mental hospital. Reference: RCW 48.44.342, RCW 48.46.292.	25	X	
13	All plans must include provisions to assure that dependents shall have the right to continue coverage in the event of loss of eligibility by the principal enrollee. Reference: RCW 48.44.400, RCW 48.46.480.	26	X	

#	STANDARD	PAGE	PASS	FAIL
14	All plans must provide coverage for the formula necessary for the treatment of phenylketonuria (PKU). Reference: RCW 48.44.440, RCW 48.46.510, WAC 284-44-450, WAC 284-46-100.	26	X	
15	All plans shall offer optional coverage for the treatment of temporomandibular joint disorders (TMJ). Reference: RCW 48.44.460, RCW 48.46.530, WAC 284-44-042, WAC 284-46-506.	26	X	
16	All group plans must contain, or incorporate by endorsement, provisions guaranteeing continuity of coverage. Reference: RCW 48.43.035(2), WAC 284-43-730(1).	26	X	
17	All plans that include pharmacy services coverage must include the required disclosure statement. *Effective July 1, 2001.* Reference: WAC 284-43-815.	26	X	
18	All plans must offer substitution of home health care in lieu of hospitalization or institutionalization. Reference: RCW 48.44.320, WAC 284-44-500, WAC 284-46-500.	26	X	
19	All plans that exclude or limit experimental and investigational prescriptions, treatments, services, or procedures must include a definition of experimental and investigational. Reference: WAC 284-44-043, WAC 248-46-507.	26	X	
20	If the health plan contains provisions for the reduction of benefits, the provisions shall comply with the Standards for Coordination of Benefits. Reference: Chapter 284-51 WAC.	26	X	
21	All group plans must offer supplemental coverage for mental health treatment. If mental health treatment is included, the specified statement as defined must be included in the contract. Reference: RCW 48.44.340, RCW 48.46.290, WAC 284-43-810.	26	X	
22	All group plans shall provide benefits for the treatment of chemical dependency. All contract benefits for the treatment of chemical dependency must comply with the specified standards. Reference: RCW 48.44.240, RCW 48.46.350, Chapter 284-53 WAC.	27	X	
23	An enrollee may pay premium directly to the health carrier in the event of a labor dispute. Reference: RCW 48.44.250, RCW 48.46.360.	28	X	
24	All group plans must provide benefits for prenatal diagnosis of congenital disorders. Reference: RCW 48.44.344, RCW 48.46.375.	27	X	

#	STANDARD	PAGE	PASS	FAIL
25	All group plans must include an offer to include an optional continuation provision. Reference: RCW 48.44.360, RCW 48.46.440.	28	X	
26	All group plans must include a provision granting a person covered by the plan the right to obtain a conversion agreement upon termination of the person's eligibility. Reference: RCW 48.44.370, RCW 48.46.450, Chapter 284-52 WAC.	27	X	
27	All group plans must provide coverage for neurodevelopmental therapies for individuals age 6 and under. Reference: RCW 48.44.450, RCW 48.46.520.	27	X	
28	Every health care service contract shall conform to the prescribed format standards and contain the prescribed contract standards. Reference: WAC 284-44-030, WAC 284-44-040.	27	X	
29	All plans offered by a health care service contractor shall contain provisions stating that the services received by a registered nurse or advanced registered nurse practitioner will not be denied. Reference: WAC 284-44-045.	27	X	
30	All health care service contractor group plans shall offer coverage for chiropractic care on the same basis as any other care. Reference: RCW 48.44.310(1).	27	X	
31	A health care service contractor shall produce and provide certificates of coverage to the employer for distribution to each covered employee. Reference: WAC 284-44-050.	28	X	

Provider Contracts:

#	STANDARD	PAGE	PASS	FAIL
1	No individual health care provider may be required by law or contract in any circumstances to participate in the provision of a specific service if they object to so doing for reason of conscience or religion. Reference: RCW 48.43.065(2)(a)	31	X	
2	All provider contracts shall contain language holding the enrolled participant harmless should the Company fail to pay for health care services. Reference: RCW 48.44.020(4), RCW 48.46.243(1) and (4), WAC 284-43-320(2).	32	X	
3	All provider contract forms must be filed with and approved by the OIC prior to use. Reference: RCW 48.44.070, RCW 48.46.243(3), WAC 284-43-330.	32	X	

#	STANDARD	PAGE	PASS	FAIL
4	Provider contracts shall contain provisions obligating the provider to provide services for the duration of the period after an HMO or HSCS's insolvency for which premium payment has been made and until the enrolled participant's discharge from inpatient facilities. Reference: RCW 48.44.055(2), RCW 48.46.245(2).	32	X	
5	An HMO may not discriminate against a qualified doctor of osteopathic medicine and surgery solely because that practitioner was board certified or eligible under an approved osteopathic certifying board instead of under an approved medical certifying board. Reference: RCW 48.46.575.	32	X	
6	All provider contract forms must contain and adhere to the prescribed standards. Reference: WAC 284-43-320 through WAC 284-43-340.	33		X
7	The definition of emergency medical condition must comply with required definitions. Reference: RCW 48.43.005(11), WAC 284-43-130(6).	34		X
8	All plans must include every category of provider. Reference: WAC 284-43-205, RCW 48.43.045	32	X	

Claims:

#	STANDARD	PAGE	PASS	FAIL
1	The Company shall provide no less than urgent and emergency care to a child who does not reside in the Company's service area. Reference: RCW 48.01.235(3).	37	X	
2	The Company shall not retrospectively deny emergency or nonemergency care that had prior authorization. *Effective July 1, 2001.* Reference: RCW 48.43.525(1).	37	X	
3	The Company shall not retrospectively deny an individual prescription drug claim that had prior authorization. Reference: RCW 48.44.465, RCW 48.46.535.	37	X	
4	The Company shall not deny benefits for any service performed by a denturist if the service performed was within the lawful scope of such person's license, and the agreement would have provided benefits if services were performed by a dentist. Reference: RCW 48.44.500, RCW 48.46.570, RCW 48.43.180	37	X	
5	The Company shall pay or deny 95% of all claims within sixty (60) days of receipt. *Effective November 11, 1999.* Reference: WAC 284-43-321(2).	37	X	

#	STANDARD	PAGE	PASS	FAIL
6	The denial of any claim must be communicated to the provider or facility with the specific reason claim denied. Reference: WAC 284-43-321(4).	37	X	
7	The Company maintains a documented utilization review program with descriptions and conducts utilization review within the prescribed format defined. Reference: WAC 284-43-410, RCW 48.43.520.	38	X	
8	The Company administers Coordination of Benefits provisions as required. Reference: Chapter 284-51 WAC.	38	X	

APPENDIX 1

Advertising Standard #5:

The Company complies with the Washington Disability Insurance Advertising Regulations. Reference: WAC 284-50-010 through WAC 284-50-230.

OIC ID #	Company Form #	Description	WAC 284-50-200
51	None	New York Times Ad (02-04-00)	X

APPENDIX 2

Complaint Standard #5:

Response to communications from the OIC must be within 15 business days of receipt of the correspondence. The response must contain the substantial information requested by the OIC. Reference: WAC 284-30-650, Technical Advisory T 98-4.

OIC #	Company Appeal #	# of Days to Complete Response
4	73964	31
8	76437	31
20	88251	33
29	94915	17
31	98747	19

APPENDIX 3

Agent Activity Standard #1:

The Company ensures that agents and brokers are licensed for the appropriate line of business with the State of Washington prior to allowing them to solicit business or represent the Company in any way. Reference: RCW 48.17.060(1) and (2), RCW 48.44.011(2), RCW 48.46.023(2).

New Business/Inforce Groups (HMO)

Agent Name	Group Effective Date	License Date	HMO Appointment Date
Dam, My	7/1/01	None	None
Watson Wyatt	1/1/00	None	None
Shirilla, Jennifer*	7/1/00	3/9/98*	5/22/98*

*Agent's appointment was cancelled 2/17/00. Agent's license expired 3/5/00.

Quotes (HCSC)

Agent Name	Quote Date	License Date	HCSC Appointment Date
Persing, Dyckman & Toynbee	8/23/01	10/29/70*	2/5/98*

*Agency license and appointment cancelled 5/12/01.

Quotes (HMO)

Agent Name	Quote Date	License Date	HMO Appointment Date
Sundquist, Terri	7/6/01	None	None
Starkey, Cheri	7/13/01	None	None
Gigurere, Fabien Francois	7/30/01	None	None
Frawley, Diane	7/30/01	None	None
Persing Dyckman & Toynbee*	8/23/01	10/29/70*	7/13/98*
David & Wilson Coordinated Benefits	9/13/01	None	None

*Agency license and appointment cancelled 5/12/01.

Marketing Personnel (HCSC and HMO)

Name	Title	Marketing Dept Hire Date	WA State License Date	HCSC Appt Date	HMO Appt Date
Acevedo, C	Inside Sales Rep	2/5/01	3/22/01	**4/13/02**	**4/13/01**
Allen, D	Acct Mgr	3/3/97	10/28/94	**8/28/97**	**8/17/97**
Arnott, W	Client Mktg Specialist	10/5/98	6/26/98	**7/8/99**	8/10/98
Arnott, W	Client Mktg Specialist	4/9/01	6/26/98	**6/14/01**	**6/14/01**
Battista, N	Sr Acct Mgr	4/27/98	**10/9/98**	**7/8/99**	**12/4/98**
Bennetsen, R	Sales Rep	1/30/98	8/8/96	**7/8/99**	**5/22/98**
Bloomfield, A	Acct Service Rep	9/21/98	6/10/98	**7/8/99**	8/17/98
Calozza, L	Acct Mgr	9/11/00	**11/29/00**	**11/29/00**	**11/29/00**
Carreiro, J	Sale Support Specialist	10/2/00	**5/3/01**	**5/21/01**	**5/21/01**
Carroll, C	Acct Executive	6/6/94	**3/14/97**	**3/14/97**	**3/23/98**
Demers, W	Sr Acct Mgr	4/19/99	3/6/97	**7/8/99**	**7/13/99**
Dennehy, D	Acct Executive	9/5/97	8/4/97	**7/8/99**	**3/23/98**
Erickson, G	Acct Executive	11/9/98	2/17/95	**7/18/99**	12/4/98
Gable, L	Acct Mgr	4/8/96	3/18/91	**7/8/99**	**3/23/98**
Gowin, R	Sales Rep	12/1/97	12/31/97	**7/8/99**	**3/23/98**
Gregson, J	Sales Rep	1/26/98	3/25/98	**7/8/99**	8/17/98
Guiberson, H	Sales Mgr	3/18/96	**4/18/00**	**4/18/00**	**4/18/00**
Halling, S	Sr Acct Mgr	10/5/98	11/2/98	**7/8/99**	12/11/98
Hesse, B	Sr Acct Mgr	1/26/98	**4/13/98**	**7/8/99**	**5/22/98**
Hickey, J	Business Development Director	6/17/90	11/4/70	**7/8/99**	**3/23/98**
Houtcooper, M	Marketing Strategy Analyst	2/1/99	**6/3/99**	**7/8/99**	**7/13/99**
Jackling, M	Acct Executive	2/2/98	10/27/89	**2/26/98**	**8/17/98**
Johnson, D	Sr Acct Mgr	10/14/96	**11/10/97**	**2/8/00**	**2/8/00**
Kalso, D	Client Mktg Specialist	3/2/98	11/16/88	**7/8/99**	**5/22/98**

Name	Title	Marketing Dept Hire Date	WA State License Date	HCSC Appt Date	HMO Appt Date
Keaton, H	General Mgr	8/10/98	7/17/01	8/10/01	8/10/01
Kitchin, W	Acct Exec	2/23/98	7/1/92	7/8/99	5/22/98
Knutson, L	Acct Exec	4/6/98	4/30/98	7/8/99	8/17/98
Krebs, N	Acct Mgr	4/19/99	4/14/99	7/8/99	7/13/99
Kreiling, S	Sales Mgr	10/6/97	1/5/98	7/8/99	3/23/98
Kussie, T	District Mgr	6/29/92	12/31/97	7/8/99	3/23/98
LeBrun, S	Sr Acct Mgr	3/19/79	5/9/91	7/8/99	3/23/98
Luscomb, M	Sr Acct Mgr	11/3/97	2/27/98	7/8/99	5/22/98
Moore, K	Sr Acct Mgr	4/15/99	9/8/99	10/6/99	10/6/99
Oyer, J	Acct Executive	9/11/96	7/14/99	12/21/99	7/14/99
Packard, A	Acct Mgr	5/16/94	1/7/98	1/7/98	9/4/98
Perrault, M	Acct Mgr	2/1/95	6/3098	6/30/98	9/4/98
Persson, S	Acct Mgr	9/8/97	3/9/98	7/9/99	5/22/98
Scheide, A	Sales Support Product Specialist	5/18/98	8/10/98	7/8/99	9/23/98
Seabrooks, N	Business Development Director	2/1/01	8/1/01	8/27/01	8/27/01
Seabrooks, S	Acct Executive	2/1/01	6/21/01	4/2/02	4/2/02
Smith, J	Sr Acct Executive	6/22/92	8/10/98	7/8/99	9/23/98
Strickland, M	Sales Rep	6/17/96	7/11/97	7/8/99	3/23/98
Studer, P	Sr Acct Mgr	4/14/97	7/8/97	7/8/99	3/23/98
Taggert, J	Acct Mgr	4/27/98	7/27/98	7/8/99	8/17/98
Toomey, D	Busness Development Director	2/1/01	7/24/01	8/7/01	8/7/01
VonReumont, K	Acct Service Rep	1/24/94	7/10/98	7/10/98	9/4/98
Wagner, M	Sales Mgr	3/2/98	3/25/98	7/8/99	5/22/98
West, J	Acct Service Mgr	3/20/00	5/3/00	12/14/00	5/3/00
Wiggins, M	Sr Acct Mgr	6/22/97	12/12/97	12/12/907	9/4/98
Williams, C	Sales Mgr	11/30/98	1/21/99	7/8/99	3/23/98
Winfield, M	Mgr of	10/20/97	11/20/97	7/8/99	3/23/98

Name	Title	Marketing Dept Hire Date	WA State License Date	HCSC Appt Date	HMO Appt Date
	Business Services				
Wright, S	Acct Executive	2/23/98	4/30/98	7/8/99	8/17/98

APPENDIX 4

Agent Activity Standard #2:

The Company ensures that agents are appointed to represent the Company prior to allowing them to solicit business on behalf of the Company. Reference: RCW 48.17.160(1), RCW 48.44.011(2), RCW 48.46.023 (2).

New Business/Inforce Groups (HMO)

Agent Name	Group Effective Date	License Date	HMO Appointment Date
Heffernan Insurance Brokers	11/1/00	3/12/91	None
Krebs, Nicole	9/1/00	4/14/99	None*

*Agent held appointment from 7/13/99 to 6/12/00. Appointment cancelled 6/12/00. Case written after appointment was cancelled.

Quotes (HCSC)

Agent Name	Quote Date	License Date	HCSC Appointment Date
Wood, Jolene (Raleigh Schwarz & Powell)	7/26/01	11/3/99	None
McGrath, Wendi (Raleigh Schwarz & Powell)	10/8/01	3/4/99	None
Johnson, Shelly	7/30/01	2/1/01	None

Quotes (HMO)

Agent Name	Quote Date	License Date	HMO Appointment Date
McCrary, Stachia (Raleigh Schwarz & Powell)	7/23/01	8/28/98	None
Wood, Jolene (Raleigh Schwarz & Powell)	7/26/01	11/3/99	None
Johnson, Shelly	7/30/01	2/1/01	None
Osborn, Bonnie L.	10/8/01	2/5/01	None

APPENDIX 5

Provider Contract Standard #3: All provider contract forms must be filed with and approved by the OIC prior to use. Reference: RCW 48.44.070, RCW 48.46.243(3), WAC 284-43-330.

OIC ID #	Description
S1	Virginia Mason Medical Center

APPENDIX 6

Provider Contract Standard #2: All provider contracts shall contain language holding the enrolled participant harmless should the Company fail to pay for health care services. Reference: RCW 48.46.243(1), RCW 48.46.243(4), WAC 284-43-320(2).

OIC ID #	Form #	Description
S4, S12, S35	WA\Physician Group 4 (10/98)	Physician Group Agreement
S5, S16, S24, S27, S32, S36	38180\66\00020.AGM/8.29.97	Physician Group Agreement
S7, S10	WA\PCP 1.2 (11/96)	Primary Care Physician Agreement
S9, S15, S39, S42	WA\Physician Group 5 (5/00)	Physician Group Agreement
S13, S33, S46	WA\SPEC 3 (12/97)	Specialist Physician Agreement
S14, S47	WA\Provider 1.2 (11/96)	Provider Agreement
S18, S26	WA\SPEC 1.2 (11/96)	Specialist Physician Agreement
S19, S28	WA\Physician Group 6 (4/01)	Physician Group Agreement
S20, S37, S40, S44, S45, S49, S50, S52, S53, S54, S56	WA\SPEC 1.0 (11/96)	Specialist Physician Agreement
S34	WA\IPA 3 (12/97)	Independent Practice Association

APPENDIX 7

Provider Contract Standard #6: All provider contract forms must contain and adhere to the prescribed standards. Reference: WAC 284-43-320 through WAC 284-43-340.

OIC ID #	Form #	Description
S1	38180\66\MASVM.DOC/7.23.97	Virginia Mason Medical Center Master
S5, S16, S24, S27, S31, S32, S36, S55	38180\66\00020.AGM/8.29.97	Physician Group Agreement
S7, S10	WA\PCP 1.2 (11/96)	Primary Care Physician Agreement
S14	WA\Provider 1.2 (11/96)	Provider Agreement
S20, S37, S40, S44, S45, S49, S50, S52, S53, S54, S56	WA\SPEC 1.0 (11/96)	Specialist Physician Agreement
S18, S26, S47	WA\SPEC 1.2 (11/96)	Specialist Physician Agreement
S13, S33, S46	WA\SPEC 3 (12/97)	Specialist Physician Agreement
S34	WA\IPA 3 (12/97)	Independent Practice Association
S8	WA\PCP 4 (10/98)	Primary Care Physician Agreement
S21, S29, S48	WA\SPEC 4 (10/98)	Specialist Physician Agreement
S4, S12, S35	WA\Physician Group 4 (10/98)	Physician Group Agreement
S25, S41, S43	WA\Provider 4 (3/99)	Provider Agreement
S30	WA\Provider Group 4 (3/99)	Provider Group Agreement
S59	WA\Ancillary 4 (3/99)	Ancillary Services Agreement
S2, S6, S11, S13, S17	WA\IPAII 4 (4/99)	Independent Practice Association
S9, S15, S39, S42, S46	WA\Physician Group 5 (5/00)	Physician Group Agreement
S23	WA\Spec 6 (12/00)	Specialist Physician Agreement
S19, S28	WA\Physician Group 6 (4/01)	Physician Group Agreement
S28	WA\Facility 6 (4/01)	Facility Agreement
S57	WA\BHCAII 1 (1/98)	Behavioral Health Contractor Agreement

Missing Files

OIC ID #	PROVIDER
S22, S51	American Whole Health Network
S58	Bailey Boushey House

APPENDIX 8

Provider Contract Standard #7: The definition of emergency medical condition must comply with required definitions. Reference 48.43.005(11), WAC 284-43-130(6).

OIC ID #	Form #	Description
S1	38180\66\MASVM.DOC/7.23.97	Virginia Mason Medical Center
S5, S16, S24, S27, S31, S32, S36, S55	38180\66\00020.AGM/8.29.97	Physician Group Agreement
S7, S10	WA\PCP 1.2 (11/96)	Primary Care Physician Agreement
S14	WA\Provider 1.2 (11/96)	Provider Agreement
S20, S37, S40, S44, S45, S49, S50, S52, S53, S54, S56	WA\SPEC 1.0 (11/96)	Specialist Physician Agreement
S18, S26, S47	WA\SPEC 1.2 (11/96)	Specialist Physician Agreement
S13, S33, S46	WA\SPEC 3 (12/97)	Specialist Physician Agreement
S34	WA\IPA 3 (12/97)	Independent Practice Association
S41, S43	WA\Provider 4 (3/99)	Provider Agreement
S30	WA\Provider Group 4 (3/99)	Provider Group Agreement
S25, S59	WA\Ancillary 4 (3/99)	Ancillary Services Agreement
S28	WA\Facility 6 (4/01)	Facility Agreement
S57	WA\BHCAII I (1/98)	Behavioral Health Contractor Agreement

Aetna

Sanford D. Howie
Compliance Manager, West Region
Aetna Health Inc.
6303 Owensmouth Ave., 8th Floor
Woodland Hills, CA 91367
Phone (818) 932-6362
Fax (818) 932-6370

VIA UPS

March 6, 2003

James T. Odiorne, CPA, JD
Deputy Insurance Commissioner
Company Supervision Division
5000 Capitol Boulevard
Tumwater, WA 98501

Re: Report of Market Conduct Examination
Aetna Health Inc., NAIC #95484
Aetna Health of Washington Inc., NAIC #47060

Dear Mr. Odiorne:

We are in receipt of the draft report of the examination for our review of the factual material presented therein and have the following comments and corrections.

In General Examination Standard #2, it is stated, in part, that the Companies were not able to readily produce documents requested by the examiners and that of the 21 additional information requests, the Companies required extensions on 11 in order to gather the requested information. The statutory references given for this standard do not address timeliness standards but instead require companies to submit their books and records relating to their operation for financial condition and market conduct examinations and in every way facilitate them. The Companies believe that they adhered to this standard.

Timeliness standards are addressed under WAC 284-30-650 and give carriers 15 business days from receipt of an inquiry to respond to the inquiry. We are assuming that this standard also applies to requests made during the course of a market conduct examinations. If this is correct, the OIC did not adhere to its own standards when requesting those 21 items of additional information from the Companies. The Companies were initially given thirteen to twenty-one *calendar* days to respond to requests for information, which did not take into account the fact that it took up to six days after the request date for us to receive the request.. Nonetheless, we adhered to the OIC-requested timeframes or to the extensions in virtually every case, and since the standard is 15 business (as opposed to calendar) days, we believe we met the timeliness requirement of the law. Therefore, we do not believe that the Companies should have failed this standard.

The Companies also failed Company Operations & Management Standard #3. This is based on the examiner's conclusion that including Norman Seabrooks, a member of the plan, on the board does not fulfill the requirement that the board membership consist one-third of consumers who are representative of the enrolled population. The two citations upon which this conclusion is based do not explicitly prohibit company employees from fulfilling this role. The Companies would respectfully suggest that this finding be considered a "pass with comment" rather than a fail.

The Companies would like to comment on the findings with regard to Agent Activity Standards 1 and 2. The findings are based, in part, upon the examiners' conclusion that some agents were not licensed, and some were not appointed, until after their positions with the Company started.

The relevant statute sections state, however; "no person ... shall act as or hold himself out to be an agent..." unless then licensed ["appointed"] by the insurer. It is our position that the mere hiring of a person does not equate to that person's "holding themselves out" as an agent. It is the activities undertaken by that individual that determine whether licensure or appointment is required.

Lastly, we would like to make the following corrections.

There has been a change in the Company Management & Operations information provided to the Office of Insurance Commissioner (OIC) earlier during the examination process.

Thomas Ryan Williams was removed as a member of the board of directors of the Washington companies being examined effective January 6, 2003 and was removed as President effective January 14, 2003.

Ellen Suzanne Daly has been appointed as a member of the board of directors of the Washington companies being examined effective January 6, 2003 and to the position of President effective January 14, 2003.

There is a correction to the Company History. Prudential Healthcare was not acquired by Aetna until August 6, 1999. There is also a correction to the grievance and appeals process. There are only three levels to this process.

We have no other comments on the facts presented.

Sincerely,

Sanford D. Howie
Compliance Manager